

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

32144

State File No.

Registrar's No.

Registration District No. 17

Primary Registration District No. 3045

1. PLACE OF DEATH:

(a) County Mississippi  
(b) City or town Charleston  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
303 Brooklyn St.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Arzella Woods

3. (b) If veteran, name war ----- 3. (c) Social Security No. -----

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife John Woods 6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased October 20, 1901  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
41 10 1 hr. min.

9. Birthplace Cotton Plant, Ark.  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business -----

12. Name Peter Robinson  
(Unknown) Virginia

13. Birthplace -----  
(City, town, or county) (State or foreign country)

14. Maiden name -----  
(Unknown) Georgia

15. Birthplace -----  
(City, town, or county) (State or foreign country)

16. (a) Informant -----  
(b) Address 303 Brooklyn St.

17. (a) Burial (b) Date thereof Aug. 27, 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Charleston, Mo.

18. (a) Signature of funeral director -----  
(b) Address Cape Girardeau, Mo.

19. (a) 9/3/43 (b) -----  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mississippi  
Charleston  
(c) City or town -----  
(If outside city or town limits, write "RURAL")  
(d) Street No. 303 Brooklyn St.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country -----

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 21  
year 1943 hour 6 minute 30 P.M.

21. I hereby certify that I attended the deceased from 8-16- 1943 to 8-21- 1943

that I last saw him alive on 8-16- 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia  
Duration 4 days

Due to Chronic Nephritis 4mmms

Due to -----

Other conditions (Include pregnancy within 3 months of death)

Major findings:  
Of operations 131

Of autopsy -----  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) -----  
(b) Date of occurrence -----  
(c) Where did injury occur? ----- (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? -----

While at work? ----- (Specify type of place) (e) Means of injury -----

23. Signature W.A. Fungal (M. D. or other)  
Address 204 S. Locust St. Charleston, Mo. signed 8-27-43

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SEP 27 1943

RECEIVED

District Health Office No. 2,

District File Number 943-1116

Date Filed 9-13-43

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed Frank Sparks

Licensed Embalmer No. 3450

P. O. Address Cape Girardeau

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.